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## Lifecare/Retirement Center Industry—1985

**1985 EDITION**

*5th ANNUAL REPORT ON THE LIFECARE/RETIREMENT INDUSTRY IN THE UNITED STATES*


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# Comments from around the country

## FROM CHICAGO

Reflecting activity nationwide, there is considerable interest in the development of mid- to upscale elderly housing in the Chicago area. From supply and competitive standpoints, the area's market is changing.

During the past year, new developments were marketed and opened in areas ranging from Chicago's North Side to suburban DuPage County. A suburban project in Lombard experienced a brisk absorption rate, apparently aided by a 90 percent refundable entrance fee.

Well over 2,000 additional independent living units are in the planning or active marketing stages. DuPage County and the Northwest corridor suburban area are considered the most appealing by prospective developers. While interest in establishing projects is high, facilities representing hundreds of additional units were blocked in the past year. Zoning, financing and organizational problems accounted for this.

Local developments are departing from the traditional, pure lifecare concept. Recently opened or planned projects include several featuring refundable entrance fees and strictly rental units with no nursing home care provided on-site. Area developers are attempting to focus their projects on an increasingly sophisticated elderly market.

Recent and proposed project sponsors include real estate developers, hospitals, for-profit entity and nonprofit group partnerships and church affiliated groups, once the primary developers of area facilities. New projects in the active planning stages range from 150+ to 350+ units in size.

The Chicago area elderly housing development market is active and changing. If presently proposed projects are developed, there will be many units available to the growing elderly population.

Ralph A. Beardsley
*Chicago*

## FROM CLEVELAND

Strong interest in the lifecare industry has been expressed throughout Ohio over the past year. As the elderly population increases, interest in this type of development is heightened.

Most of the continuing care facilities in Ohio are nonprofit with a religious affiliation. Many report high occupancy rates with sizeable waiting lists. New proprietary operations are being developed by nursing home owners and real estate developers. A trend to straight rental projects is developing and seems to be appealing to the elderly.

The Ohio lifecare trend leans toward both independent living units, preferably ranch homes, and the full levels of health care facilities which provide security to residents. Our elderly population is choosing to live independently as long as possible until they have a need for skilled nursing care. This causes a decrease in need for assisted-living units.

The State Department of Health has recognized the increasing need for full service lifecare communities and has proposed legislation to allow for an exemption from State Certificate of Need (CON) approval. The legislation would allow three full care lifecare/continuing care communities with nursing capacity per Health System Agency area to be exempt from CON approval.

The outlook for the industry in Ohio is favorable. Although there are many communities in the planning stages, the opportunity to enter an ever growing market is present, and the market is strong.

Melinda M. Rath
*Cleveland*

## FROM COLUMBUS

Interest in lifecare communities in Columbus and Central Ohio has intensified in the past several months. New projects are being constructed or planned for the immediate future. Unlike many communities which require an entry fee, the communities in Central Ohio are congregate living facilities, more comparable to conventional apartment projects offering amenities centered around the needs of the elderly.

Monthly rental rates for a single resident range from $720 for a one bedroom unit to $930 for a two bedroom unit, including one meal daily. Additional charges are rendered for each additional resident, averaging between $200 and $300. Health related services are charged as they are required.

The average occupancy rate for lifecare communities in Columbus exceeds 95 percent with several projects reporting significant waiting lists. As Columbus continues to grow, the additional need for lifecare projects appears to be quite high.

C. Brent McCurdy
*Columbus*

## FROM DENVER

Interest in retirement center communties in the Rocky Mountain region has been very strong during the last year. Several trends have emerged that should have a significant impact on this market.

The first important trend is the increasing segmentation in the types of projects being built. Currently, the market is broken into three segments: low-end, middle and high-end. The low-end group typically is composed of older, nonprofit, government subsidy centers targeted to attract low-income elderly residents living on Social Security and limited retirement income. These projects usually are designed as apartment complexes and offer no services to their residents. Monthly fees range from $150 to $400. Very few of these projects are currently being built.

The middle-segment projects are the "hot area" in this region. Both nonprofit agencies and private developers are excited about this segment and are building these projects, which stress independent living yet offer a full range of services, short of full-time nursing care. The services typically include meals, transportation, social/recreational activities and security. Monthly rents range from $650 to $1,500 and include all services.

The third segment, the high-end projects, also is being considered by developers. However, there is not as much activity in this market as in the middle-segment projects. Typically, these projects offer residents larger units, more services and a more luxurious setting. Usually the high-end projects differentiate themselves from the other projects through their greater cost to the residents; however, few endowment projects exist in the region.

The second major emerging trend in the Rocky Mountain region is the use of innovative financing techniques. In addition to the traditional rental approach, projects are now being sold as cooperatives and condominiums. Many developers are using industrial revenue bonds to finance their projects with credit enhancements from local lenders.

What does the future hold for retirement centers in the Rocky Mountain region?

1. There is strong interest in developing retirement housing in several Rocky Mountain states. However, to date, most of the activity is taking place in metropolitan Denver. Colorado is expected to be the hub for retirement housing development in the region, although activity is beginning to pick up in New Mexico and Wyoming.
2. Demographically, Colorado is one of the youngest states. However, based on Laventhol & Horwath's research, approximately 20 percent of retirement center residents have relocated to Colorado to be closer to their children and grandchildren. We expect this to continue and to have a positive impact on retirement housing demand in Colorado and the Rocky Mountain region.
3. Currently, a supply of various types of retirement housing facilities is lacking. However, with development of several new facilities, we expect this situation to correct itself within the next few years. Further market segmentation is expected with groups such as the military and religious organizations building facilities of their own.
4. It also is anticipated that, with greater participation by conventional lenders, financing methods will continue to evolve.

The potential for further growth in the Rocky Mountain region retirement housing industry is very strong. This industry is expected to grow and diversify during the next several years.

Terri L. Paul
Kenneth A. Bleakly, Jr.
*Denver*

## FROM HOUSTON

Houston is currently ranked the fourth largest city in the United States in terms of population. Yet, with an elderly population (aged 65+) estimated at 208,000 in 1985, Houston has only four nonsubsidized retirement developments, totaling 835 units. The most recent project opened this year; the first to be completed in 12 years.

Three new retirement developments have recently been announced representing a total of 480 units. In addition, at least five other projects totaling more than 1,000 units are in various planning stages. However, no retirement developments are currently under construction in Houston.

The Texas Health Facilities Commission, the state agency responsible for issuing Certificates of Need (CON), will be abolished as of September 1, 1985. This will affect only those retirement developments with a health care component. It also could lead the way for large scale nursing home facilities development in a short period of time.

Trends in the Houston area include active interest in developing retirement housing. Rental properties offering few, if any, on-site nursing facilities have been the focus of recent developer activity and generally cater to the middle and upper income markets.

Paul S. Black
*Houston*

## FROM LOS ANGELES

Interest in the development potential of adult congregate living facilities (ACLFs) in portions of Southern and Central California, Phoenix and Tucson continues. Traditional continuing care retirement center development has slowed dramatically, due in part to state regulations requiring a 70 percent pre-sale of the independent living units.

A number of mixed-use, multi-level campuses are being planned for development. These proposed facilities will offer condominium units, an ACLF and a licensed convalescent hospital all on the same campus.

Hospitals are beginning to exhibit interest in the development potential of retirement center accommodations. Vertical integration opportunities seem to drive this interest.

Developers are finding the high price of desirable land sites constraining. The most desirable land parcels are very often costly and significantly larger than needed for development of a market-supportable number of units. Considerable ingenuity is necessary to determine the optimum use of residual land.

A significant number of ACLFs will be completed in the next six months. Aggressive marketing programs are now beginning for new facilities expected to be ready for residency in early 1986.

Jerry T. Quigg
*Los Angeles*

# Comments from around the country (continued)

## FROM MINNEAPOLIS

Interest in continuing care retirement centers (CCRCs) is intensifying in the Upper Midwest as a result of market and regulatory pressures. This area of the country has had a strong tradition of commitment to care for the elderly as evidenced by the amount of nursing home development and other care programs. As the size of this market increases, many are seeking the opportunity to provide services as the retired population becomes more buyer-oriented.

In addition, heavy regulation of the health care system is placing pressures on the development of alternative methods of caring for people in noninstitutional settings. Moratoriums on additional nursing home beds have maintained the supply below the natural market demand and have allowed creative business people to explore alternatives to nursing homes.

The restriction on nursing home development has provided the incentive for creative arrangements, as services of the care continuum become unbundled. Many developments are now taking on the characteristics of a market-rate rental housing development with optional service packages available to meet the needs of the individual residents.

The players in the CCRC development industry in the Upper Midwest are varied. Many real estate developers are getting involved in these developments, as the highest and best use of their land, or in the rehabilitation of existing facilities. Nursing homes with available land unable to expand their nursing home bed capacity are looking at CCRCs as a way of meeting a market demand and using their valuable land at the same time.

Major hospitals and health care systems looking to diversify away from acute, long-term care segments of the health care system are viewing CCRCs as a lucrative alternative to meet the needs of the retired population as well as to create a captive health care services market. Many ventures are structured as joint developments between developers and health care organizations. Others seek partnerships that allow the developer to develop his property while assuring the prospective residents that a reputable health care organization will be standing behind the delivery of the service components.

With each new facility, a new concept is developed, as people seek alternatives to meet the market demand. The personal care or small scale congregate setting, with more intense services supporting the activities of daily living, is becoming increasingly common. The Upper Midwest market, especially the Twin Cities and Minnesota, has long been known as a bellwether market for health care system development. Although a late entry in the retirement center industry, the Upper Midwest is taking on a similar role to the Sunbelt and is viewed as another option for retired individuals.

Thomas A. Luchi
*Minneapolis*

## FROM PHILADELPHIA

The Philadelphia area's 32 continuing care and rental retirement center communities, the largest concentration in the United States, continue to grow. Approximately 10 facilities are under development, representing approximately 1,950 additional residential apartment units. If all ten facilities proceed to opening, the available supply of apartments will increase by 21 percent to nearly 9,300 units. Not included in these estimates are 600 additional units as part of two proposed facilities in New Jersey, within 35 miles of Center City Philadelphia.

Five of the facilities and approximately half of the units will be developed and operated by for-profit entities. Several facilities will offer a refundable entrance fee opposed to the nonrefundable or amortizing fee offered by most Philadelphia facilities.

In addition, a 300-unit project in Northeast Philadelphia, constructed in 1983 but never opened, was sold in 1985 and is expected to open by the end of this year as a moderately priced rental project.

The emergence of for-profit rental projects, refundable entry fees and joint ventures between real estate developers and nonprofit sponsors represent the future trends in the Philadelphia elderly housing market.

How big and diverse will this market be in Philadelphia? Is this market in danger of being oversaturated? The answers are not clear. However, the prospects of oversaturation must be seriously considered. Facilities with established or focused market images will have a far better chance of maintaining full occupancy and, in the case of new facilities, rapid fill-up than those facilities that do not.

One other noteworthy development: Pennsylvania issued its lifecare regulations during 1985. The law, which will be administered by the Pennsylvania Department of Insurance, is designed to force adequate disclosure to residents and to insure the presence of liquid reserves equal to 12 months of debt service, or 10 percent of annual operating expenses, whichever is greater. Certificates of authority issued by the state are required for an operator to operate or market a lifecare facility in the state. In certain cases, criminal provisions apply if disclosure is found to be misleading. The statute contains no requirements that regulate profits or the accumulation of reserves in excess of the required minimums.

M. Stroud Curran
Howard Peters
*Philadelphia*

## FROM ST. LOUIS

Within a 25 mile radius of downtown St. Louis there are 2,514 retirement community units; 1,938 of these are in Missouri while 576 are in Illinois. In addition to projects currently operational, several proposed projects, on both sides of the river, are at different planning stages.

The elderly population (65 years and older) in this area is projected to comprise 14 percent of the total population by 1990, and number 289,724.

By the end of 1985, five projects will be completed adding 613 units to the metropolitan St. Louis inventory. All of these projects are being offered on a rental basis, with none offering nursing care. However, all of the traditional amenities are being offered as part of the monthly rental (i.e., meals, transportation, activities, linen service, maid service, emergency call systems and security).

These major factors account for this trend to rental units:

1. A four-year moratorium on the construction of long-term care beds in Missouri was enacted in June 1983.
2. The reluctance of the elderly to "tie-up" their funds in a project where they don't own the property.
3. The reluctance of management to make a commitment to provide nursing care in the future, thus being subject to a future liability that cannot be reasonably estimated.

This trend has led several of the established CCRCs (continuing care retirement communities) to explore the possibility of restructuring their projects by:

- Eliminating entrance or endowment fees.
- Providing substantial refunds of entrance or endowment fees.
- Discontinuing the lifecare component of their projects.

Another new trend is joint ventures between developers and local institutions that serve as "magnet groups" (i.e., churches, hospitals and nursing homes). The main ingredient is the credibility and trust that the local magnet group brings to the project.

Because the retirement community industry is still in a growth mode and the affluent elderly population continues to grow, the opportunity for additional project development in St. Louis appears to be strong.

Joe Kunkemueller
*St. Louis*

## FROM SAN FRANCISCO

Interest in retirement housing is exploding in Northern California and the West. Hospitals, physicians and real estate developers are moving quickly to position themselves in markets with large numbers of affluent elderly who are crowding waiting lists of existing facilities. Most of the planned projects are targeting affluent elderly with large amounts of equity tied up in their personal residences from the real estate boom of the 1970s.

A project has recently broken ground for a 400-unit upscale CCRC called Smith Ranch Hills/Marin. They have upgraded their already luxurious project to market to the affluent in Marin and San Francisco Counties. Based on several market surveys, the units are planned from 1,000 to 3,000 square feet in size. The extensive amenity package has been extended to include a country club type environment with four excellent restaurants that will also be open to the public. Entrance fees average in excess of $400,000. The same developer is currently evaluating building two additional facilities in Southern California.

Villa Marin is a 224-unit condominium CCRC that is 70 percent full after one month of operation because of an extensive premarketing program. Prices range from $150,000 with a monthly fee of $700, to $515,000 with a monthly fee of $1,850 for double occupancy. The larger, higher priced units sold out quickly, indicating the strength of upscale projects.

Spring Lake, a 303-unit CCRC in Sonoma County, will be available in March 1986 and is 70 percent pre-sold. The project ranges from $50,700 plus $870 a month to $166,700 plus $1,348 a month and includes a 10-unit personal care facility and a 50-unit skilled nursing facility.

The Wedgewood Group of Vancouver, Washington, which currently operates eight facilities in the Pacific Northwest, is developing three congregate care facilities with separate intermediate care facilities in Northern California and Nevada.

In Seattle, the birthplace of lifecare, there is renewed interest in the development of CCRCs. Many developers are considering projects throughout the Pacific Northwest.

Western retirement developers are targeting affluent elderly communities, including San Francisco, Marin County, Santa Clara, Santa Barbara, Laguna Beach, La Jolla and others. We believe that the market will continue to grow for retirement facilities in the West and that new and innovative ways of providing for the elderly will be found.

David Kornblum
Richard Gianello
Patrick Carroll
Walter Kopp
Lisa Langille
Robin Kornfeld
*San Francisco*

# Comments from around the country (continued)

## FROM SOUTHERN FLORIDA

Development activity in the retirement community market continues at a hectic pace in Southern Florida. Due to changes in the Florida statutes governing the types of services that require licensure as an adult congregate living facility (ACLF), a new acronym has been born to the retirement community marketplace. Along with CCRCs and ACLFs, we now see the development of ERRCs, the elderly rental retirement community, sometimes shortened to ERC (elderly rental community).

Major developers of single and multi-family housing units are aggressively entering the retirement community market. Most projects are in the ERC area. In addition, many of these projects are expected to contain personal care (assistance in daily living) units—a new criterion for ACLF licensure.

The for-profit developer has recently tended to shy away from development of CCRCs. This action is due to extensive regulation of CCRCs by the Department of Insurance, along with pre-reservation requirements (50 percent) and various liquid reserve requirements. In addition, the pre-reservation requirement often requires a marketing and advertising budget in excess of $500,000 prior to start of construction.

Demand for CCRCs, however, remains strong in the marketplace with utilization percentages often in excess of 90 percent for established communities. For new and proposed CCRCs with effective marketing programs, pre-sales of units are ranging from six to eight units per month. Successfully marketed ERCs are experiencing pre-leasing rates of eight to twelve units per month with marketing commencing during construction, approximately 10 months prior to start of operations.

Move-in (absorption) rates in new communities are averaging between six and twelve units per month. The addition of a "move-in coordinator" to the staff can enhance the transition from the present home of the resident into the retirement community.

Development of CCRCs, ACLFs and ERCs continues in Southern Florida with strong demand for, and acceptance of, these communities by an ever-increasing number of elderly households in the marketplace.

Donald Dahlfues
*Miami*

## FROM WESTERN AND CENTRAL FLORIDA

Activity in the retirement housing industry in Western and Central Florida has been strong despite tough state legislation governing entrance fees. Pre-sale and escrow requirements currently in effect have not slowed developers' interest in the lifecare market. Rental adult congregate living facilities (ACLFs), which are exempt from lifecare regulations in Florida, are increasing in popularity.

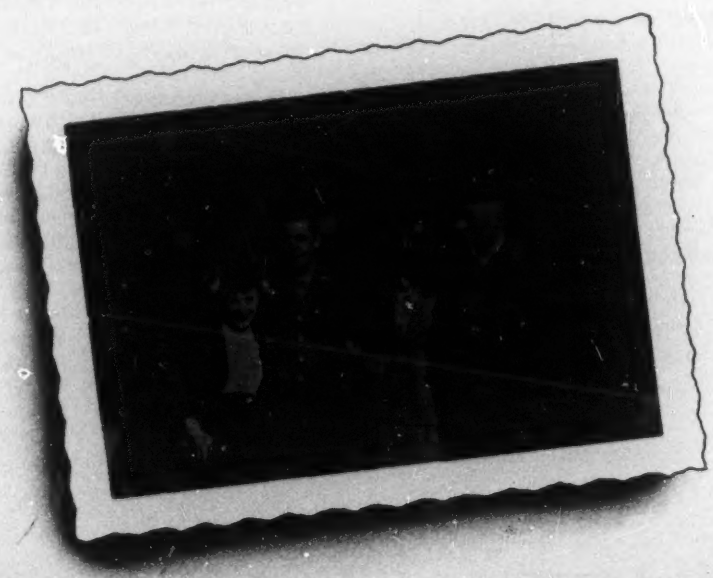
With the state elderly population expected to reach just under three million by the end of the century, Goodkin Research Corporation, Ft. Lauderdale, estimates that demand for lifecare units in Florida will reach 80,000 by the year 2000. The elderly, as a percentage of total population, in many parts of Western and Central Florida approximate 25 to 30 percent, with increases expected as the population ages. Growth in many communities' total population is attributable to net immigration, not natural population increases.

Most of the existing facilities in this part of the state are nonprofit with a religious affiliation. Newer operations are being developed primarily by nursing home or lifecare chains, or real estate developers, with an increasing number of proprietary operations. Operators report occupancy rates of more than 95 percent, and many have extensive waiting lists.

The trend, particularly in newer facilities, is toward higher entrance fees (many refundable) and lower monthly maintenance fees. Unique financing methods, such as resident bonds and condominium structures, are increasing in popularity. Garden style apartments are replacing the older, institutional-type structure. Health care services provided at most facilities include emergency call systems and 24-hour nursing stations, in addition to those facilities with on-site nursing or health centers.

The outlook for the retirement housing industry in Western and Central Florida is very favorable. The elderly are becoming more aware of retirement living alternatives, and tough state lifecare legal guidelines are expected to improve the industry's image and credibility in the eyes of potential elderly residents.

Jane E. Morgan
*Tampa*



# A success guide for retirement centers

*by Jim Moore*

Presently with much economic uncertainty and increasing complexities within the business world, a market opportunity certain to grow until the year 2035 would be welcome.

The good news is such a market exists in providing for the shelter and lifestyle needs of the elderly. The bad news is the in-rush of competition—common to all lucrative markets—will be significant. Mistakes will be made. An industry shake-out of the magnitude similar to the one in the personal computer industry may take place.

One of the best ways for participants in this emerging growth industry to survive and prosper is to ask four key questions:

1. Where has the industry come from (in the recent past)?
2. What is its status today?
3. Where is it headed?

And, perhaps the most critical question:

4. Specifically, how can an organization research, plan and execute strategies to maximize market opportunities soon to exist?

## Past trends

The previous market has generally been categorized as the lifecare industry. It operated typically through nonprofit organizational sponsorship. A fixed up-front investment and recurring monthly fees guaranteed a defined, comprehensive lifecare program.

Today, however, the market is developing a trend—the multiple option society. While multiple options are presently available, most of them are part of one central trend: the constant search for self-fulfillment and pursuit of the optimum lifestyle.

Marketing "lifestyle" rather than tangible product attributes to our older population is important. We're not selling sticks, bricks and mortar; we're selling a carefree, leisure lifestyle.

Currently, there is strong demand in all parts of the United States. No longer are leisure living communities appropriate only for previously identified retirement meccas such as Florida, California and Arizona.

Each area, each city and each project, however, must be uniquely researched and custom-designed to suit market demands. Even though demand is significant, the market will not tolerate large margins of error.

## Perceptions and misconceptions

A lack of awareness of alternative lifestyle is the best way to characterize the current leisure living market. Three groups need to be better and more accurately informed about the market. They are:

1. The end users—the elderly who might readily accept and be able to afford an alternative lifestyle.
2. Potential sponsors and the development community—an in-rush of supply not "in tune" with the marketplace could be detrimental to the image of the industry.
3. Potential lenders—nothing happens in development without adequate capital resources.

Many end users feel that the lifestyles they've heard about are too expensive. However, when comparable cost of living budgets are actually computed, most elderly prospects are pleasantly surprised. Moreover, about 90 percent of the age 65+ households live in owner-occupied housing, with approximately 60 percent owning their homes free and clear. Liquidating their equity is not easy; but, when it is accomplished, households typically have $70,000 to $120,000 of new resources working for them.

## Health care implications

We are spending over $1 billion per day on health care, and much of the cost can be attributed to the elderly. Yet, sophisticated leisure living communities allow our elderly extended *independence* through *interdependence*. This is accomplished through associations with their peer groups. These communities also provide personal and assisted living care for those who might otherwise be in nursing homes. This industry will certainly contribute to slowing rapidly escalating health care costs.

## Strong but complex market

The multiple option society trend has found its way into the retirement housing market. Three options are:

1. Type of product.
2. Amenities and services offered.
3. Payment plans.

These three options trigger hundreds of permutations and combinations—all key marketplace issues. And, each geographical market is unique. In many small to medium sized markets, being first with the right product is critical. With project development lead times of 18 to 30 months, only the most aggressive and professional organizations will consistently succeed. Improper selection of a fee or payment plan can destroy an otherwise well-conceived development.

## Marketing intensity is critical

This is another good news/bad news situation. The good news is we clearly know *who* the market is and *how* to reach them. The bad news is it is a relatively slow response market. The sense of urgency for someone aged 70 interested in an alternative lifestyle is far different than a young couple looking for an apartment or their first home. The elderly have been categorized by marketing professionals as a "be-back market."

## Setting trends, not following them

In terms of elderly mobility and migration, we cannot rely on past trends set and documented in the 1970s or the early 1980s. The reason is simple. During those times, our senior citizens had relatively few alternative lifestyle options.

That has all changed now, as projects are being both planned and completed all over the country. But as tempting as it may be, the industry must appeal to the end users in the market, not merely emulate the emerging competition.

The opportunities in our industry are great, but so are the challenges.

Jim Moore is president of Moore Diversified Services, Inc., market research and business consulting firm based in Fort Worth.

# Avoiding financial pitfalls in developing a retirement center

*by James F. Sherman*

Awareness and understanding of the retirement center industry by those persons and organizations interested in developing and operating retirement centers has increased over the past year. Many options exist to meet the housing and health care needs of the elderly. Questions being asked include:

"How can I avoid the problems experienced by facilities now insolvent?"

"How can my organization be sure that it has the best service package available to the elderly?"

"What is the key to developing, organizing and operating a successful retirement center?"

To answer these questions, let's outline the reasons for the failure of a retirement center. (And, by the way, failures do not necessarily occur during the first years of a project, but may happen several years after operations begin.)

## Common problem areas

Projects that have, however, failed during the first year of operation suffered in one or more of three areas—construction, site location or marketing issues. It continually amazes people that we list construction as a major problem. It's simple. Because the retirement center industry is still a relatively new industry, some companies are so anxious to develop their first project they may not fully recognize the unique requirements of the elderly. Examples of these requirements include a specialized kitchen and bathroom layout and placement of the electrical outlets and light switches.

Sometimes, inadequate consideration is given to the "activities" or "common" areas of the building. I have heard said a retirement center is little more than an apartment building. It's much more. It's the creation of a total concept in living—a residential facility, a fine restaurant, a "secure" place, a place of activity; it's a total lifestyle for its residents.

The architect and the contractor must build these components into the project. Several projects had to change their architectural drawings far into the construction process, and costs escalated each time a change order was authorized. This is a plan for failure. Depending on the type of construction financing, change orders can lead down a road of no return. Once the project owner has to request additional borrowings, two dynamics take place: the lender must advance additional funds or run the risk of a partially completed building, and potential residents may have to pay higher entrance, or monthly, fees. It is difficult to request higher fees from residents, once they have signed residential agreements or have been provided a fee estimate during premarketing efforts. If potential residents do not agree to required increases, the project may not be able to meet its expense requirements, including debt service, and thus the project may become insolvent. An experienced architect can prevent costly changes from occurring.

Poor site selection has been the source of difficulty for several projects. Selecting the appropriate site is a complicated issue involving many variables, including:

- Building the retirement center in the economic environment in which the project's residents presently reside, i.e., construct a project for the middle-income neighborhood.
- Choose a site large enough to meet the requirements of the project.
- Have the site located in an area conducive to the needs of the elderly. For example, the site should be accessible to physicians, shopping, places of worship and other social services, including recreation.

The last major area is marketing. Marketing a retirement center takes unique talent and understanding. Selling units in a retirement center is unlike selling real estate. It is the selling of a comfortable, secure, pleasant lifestyle. Successful marketing means understanding the characteristics and requirements of the targeted population. An owner needs a marketing organization that has experience in marketing a project similar to the one being developed.

Other factors leading to the failure of a retirement center may include:

- A high cost of construction due to changes once construction has begun resulting in too high a debt service per unit to residents.
- Financing the project with a high rate debt instrument or at a time when interest rates are above an affordable level.
- Overly optimistic forecasted project fill rates and providing insufficient working capital during the initial fill-up period, preventing the project from meeting its operating expenses.
- Failure to financially screen out residents who will be unable to pay monthly fees, which will escalate during the resident's occupancy.
- Resident contract terminology that does not allow for adequate escalation of fees to meet higher operating expenses.
- The lack of qualified management.
- Inaccurate projections of resident turnover and mortality and morbidity rates. Reasonable forecasts are especially critical for projects offering unlimited health care services without additional charge.

## Planning is the key

One of the keys to developing and operating a financially viable project is planning. Analyzing the site, developing the appropriate service package and pricing it within a realistic rate structure, and constructing a building with the correct mix of units and the appropriate unit sizes, takes a team of professionals highly qualified in retirement center development.

## Review the competition

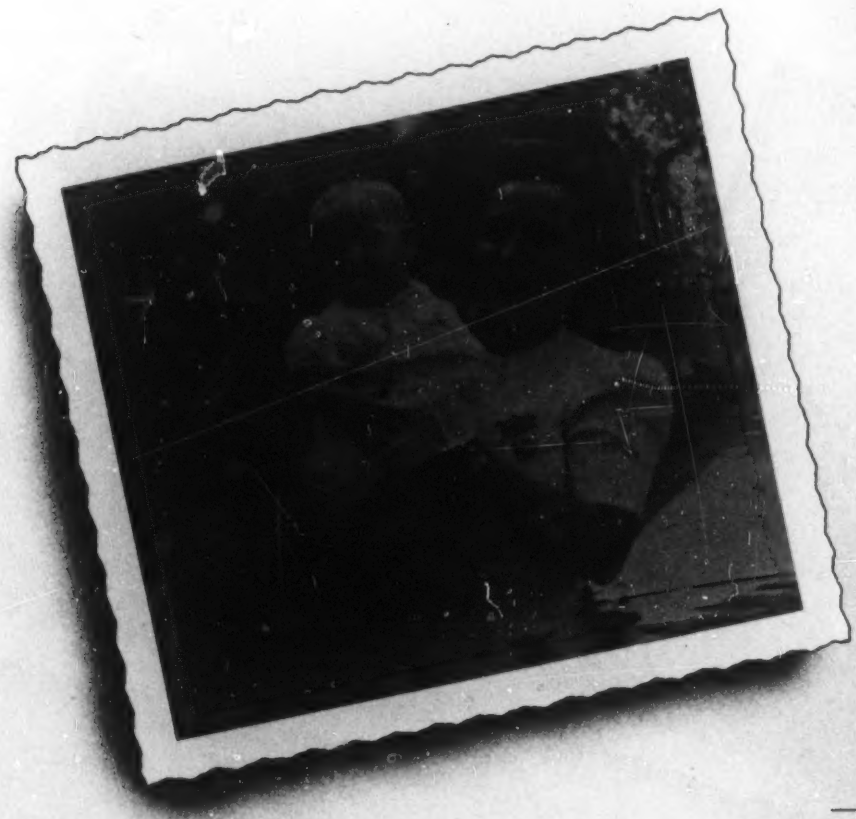
The competition must be carefully studied in regard to their location, size, services, fee structure, sponsorship and age. This includes an analysis of lifecare or continuing care retirement centers, adult congregate living facilities and, in certain situations, personal care facilities. If there have been successes or failures, the reasons for the success or failure of existing facilities should be determined to assist in understanding the marketplace. The results of this analysis provide a measurement of potential demand and a definition of the eligibility criteria, an estimate of the relevant population and the project's market penetration.

## Financial feasibility

The financial feasibility of a project is equally as important as the market feasibility. In addition to evaluating operating expenses and revenues, proprietary projects should be reviewed for income tax implications. The anticipated method of financing and its cash flow implications need equally careful analysis. Such a study should start with the developmental period, analyze the construction and resident move-in period and, finally, cover several years of normal occupancy operations (taking inflation into consideration).

Incorrect financial projections can cause fatal cash shortages, especially during the fill-up period. Realistic fill-up period projections, with adequate financial reserves in case of slower than expected move-ins, can be the difference between a project's success and failure.

Careful planning by the developer, assisted by a qualified team of professionals, will help to avoid financial pitfalls in developing a retirement center.



James F. Sherman is a Laventhol & Horwath partner based in the firm's Executive Offices in Philadelphia. He is L&H's National Director of Public Financing and Health Care Consulting.

# The lifecare/retirement center industry—1985

by Aaron M. Rose and Mark V. Lomanno

For the fifth consecutive year, Laventhol & Horwath has conducted a comprehensive survey of the retirement center industry. This industry is referred to by many different names and although some people ascribe very specific characteristics to certain names, others use the terms loosely and, frequently, interchangeably. Recognizing the confusion in nomenclature, we have expanded the title of the 1985 issue of this study to include the term "retirement center" in addition to the term "lifecare." Among the more frequently used names for the housing and services provided we find "continuing care," "life care or lifecare," "congregate living" and "retirement center." Whatever you may choose to call it, the industry is evoking tremendous interest from real estate developers, hospital managers, nursing home chains, university planners, nonprofit organizations, management companies and others seeking to develop such facilities.

Almost 600 survey questionnaires were distributed to facilities that appeared to be part of this industry. Some of the replies were not included because they were from government-assisted housing projects; others were unusable because the respondents did not answer enough of the questions. We were able to use replies from 102 facilities even though some of these questionnaires did not have responses to every question. The retirement care facilities used in the study varied greatly and included the following types of facilities:

- Operations oriented toward nursing care due to the small number of apartment units relative to nursing beds.
- Entrance fee projects, either fully refundable, partly refundable or not refundable after passage of a specific time period.
- Congregate living projects (without nursing or entrance fees).
- Projects that included virtually unlimited nursing and other health care coverages in the basic monthly fee.
- Fee structures with limited or no nursing care coverage included, but with the services available on a fee-for-service basis.
- Various sized facilities, almost all of which had nursing care on premises with slightly over half having personal care/assisted living units.

Obviously such a wide range of responses, coupled with a limited number of usable questionnaires, provides statistical information that may not be as precise as any of us would like. However, we have attempted to break down the data in the study into as many subdivisions as practical to enable readers to extract information that most closely corresponds to their type of facility.

It is important to emphasize that we were not able to create a probability sample that accurately reflects the composition of the various industry segments, because the respondents are self-selected. Nevertheless, we believe these compilations of data provide useful information if the numbers are used with care and recognized as biased estimates. It's interesting to note the results of the 1985 study (based on 1984 data) are remarkably similar in most instances to 1984 results (based on 1983 data). We are pleased that each year's study has been assembled from a greater number of replies than the preceding year. A 20 percent increase of respondents in 1985 compared with 1984 enabled us to provide additional breakdowns of the information. Some new information included in this year's study is:

- An analysis of personal care/assisted living units.
- The marketing cost per unit for facilities built in 1977 and later.
- Facility estimates of the size of the primary market area and the estimated percentages of residents coming from it.
- Analysis of entrance fees between facilities that provide nursing care coverage without extra charge and those that use a fee-for-service basis.

Most of the figures used in this study are medians and upper and lower quartiles. A median is the middle figure in a column of data arranged sequentially, either from high to low or low to high. The lower quartile is the dividing line between the lowest 25 percent and the upper 75 percent of the data group. The upper quartile is the dividing point between the upper 25 percent and the lower 75 percent of the data group. Thus, the lower quartile, the median and upper quartile divide a series of figures into four equal parts. The results of the middle half of the facilities fall between the lower and upper quartiles.

Each line item has been analyzed separately, and the medians are based on the information submitted for that line item only, since not all facilities reported data for each line. The arithmetic mean was also used occasionally. The reader is cautioned that the figures presented in this study are intended to be used as guidelines, not standards or goals. They are not an attempt by L&H to set or conform prices or operating ratios for the industry.

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## Profile of participants

Exhibits 1 and 2 are profiles of the participants in the study. The following summary of characteristics for the typical "principally retirement center" facility provides a useful point of reference since many of the study's results are stated in medians:

- Owned by a nonprofit organization.
- Located in an urban area, or possibly in a nearby suburb.
- Has 200 apartment units and 60 nursing beds. The nursing center is located on the same premises as the apartments.
- Entrance fee is not refundable after 50 months of occupancy.
- Some limited nursing care coverage is included in the monthly fee.
- Manages its own facility without assistance of a management company.
- Provides free transportation.
- Built before 1977.

Almost half of the useable responses for principally retirement center facilities had personal care/assisted living units on the premises. As a result, we have provided separate statistical information on this type of operation where appropriate. Last year only 10 percent of the facilities reported having personal care on premises, compared with 52 out of 102 this year.

The study has been divided into essentially two separate studies. The primary factor in dividing the results into sections of the report is whether the community is principally a retirement center or principally oriented toward nursing care. The definition we have adopted categorizes facilities with fewer than two apartments for each nursing bed as oriented toward nursing care. Since 33.3 percent of the respondents have less than 20 percent of the total apartments but 56 percent of the nursing beds, it would distort certain statistical information if both types of retirement centers were grouped together.

As you read through the study you will see that facilities oriented toward nursing care have fewer apartment units and have a population that, upon entry, is somewhat older and more frail as indicated by the substantially higher turnover ratios (deaths and permanent transfers to the nursing center). From an operational viewpoint, these facilities have a considerably lower average dietary payroll per meal, a higher average housekeeping payroll per square foot and a larger ratio of employees to the total number of residents and patients combined than a principally retirement center. By reporting the results of the two types of operations separately, many of the statistical distortions have been removed.

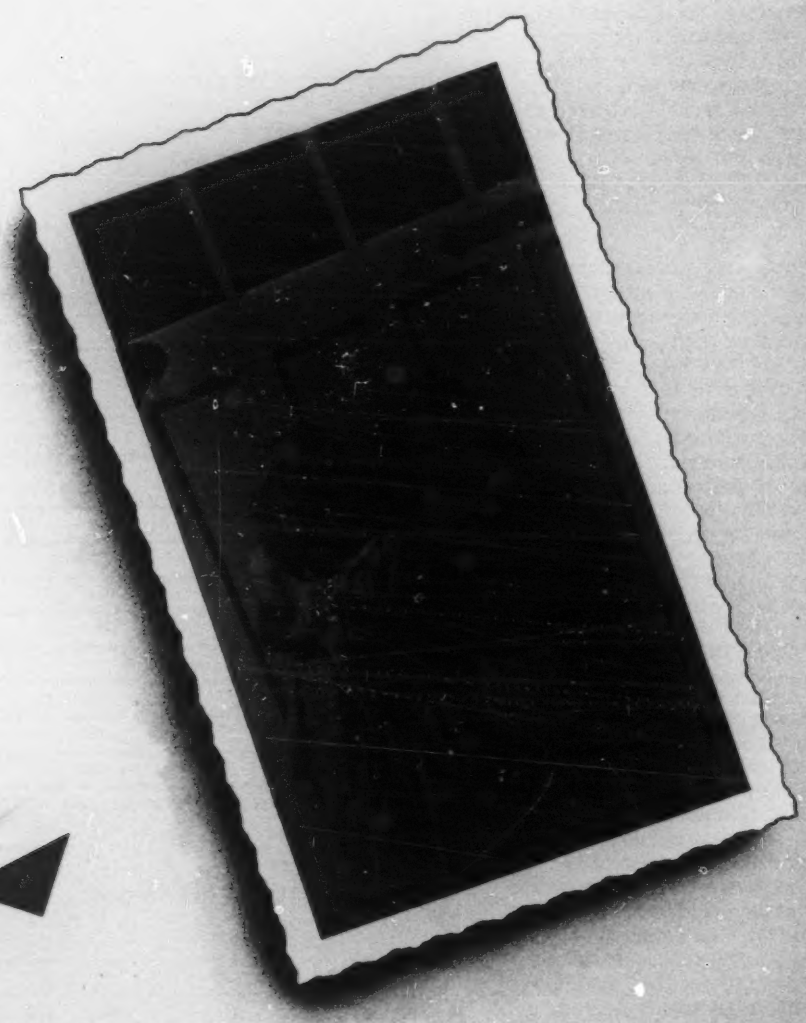
**EXHIBIT 1**
Profile of Respondents—
Number of Respondents Within Each Category

| | Number of Respondents | | |
|---|---|---|---|
| | Total | Principally Retirement Center | Oriented Toward Nursing Care* |
| **All Facilities** | 102 | 68 | 34 |
| **Owned by a Nonprofit Organization:** | | | |
| Yes | 98 | 65 | 33 |
| No | 4 | 3 | 1 |
| **Location:** | | | |
| Urban Area | 49 | 34 | 15 |
| Suburban Area | 43 | 30 | 13 |
| Rural Area | 10 | 4 | 6 |
| **Size of Facility:** | | | |
| Under 200 Apartments | 63 | 34 | 29 |
| 200 Apartments or More | 39 | 35 | 4 |
| **Entrance Fees:** | | | |
| 50% to 100% Refundable Under All Conditions | 10 | 7 | 3 |
| No Refund Except for Trial Period | 11 | 8 | 3 |
| No Refund After 50 Months or Less | 25 | 16 | 9 |
| No Refund After Periods Longer Than 50 Months | 22 | 16 | 6 |
| Projects Without Entrance Fees | 13 | 6 | 7 |
| **Nursing Care Coverage Included in Monthly Fee:** | | | |
| **Virtually Unlimited Coverage:** | | | |
| Built Before 1977 | 25 | 19 | 6 |
| Built 1977 and After | 10 | 7 | 3 |
| **Limited or No Coverage:** | | | |
| Built Before 1977 | 46 | 23 | 23 |
| Built 1977 and After | 9 | 9 | 0 |
| **Retain a Management Company:** | | | |
| Food Service | 28 | 17 | 11 |
| Overall Management | 16 | 13 | 3 |
| **Region of Country:**** | | | |
| Northeast | 11 | 6 | 5 |
| North Central | 38 | 20 | 18 |
| South | 28 | 21 | 7 |
| West | 25 | 21 | 4 |
| **Provide Free Transportation** | 78 | 53 | 25 |
| **Age of Apartments:** | | | |
| Pre-1977 | 77 | 47 | 30 |
| 1977 and Later | 19 | 16 | 3 |
| **Nursing Center on Premises** | 98 | 64 | 34 |
| **Personal Care/Assisted Living Units on Premises** | 52 | 31 | 21 |

*Facilities with fewer than two apartments for each nursing bed.
**Northeast—CT, DE, ME, MA, NH, NJ, NY, PA, RI, VT
North Central—IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI
South—AL, AR, DC, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV
West—AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

**EXHIBIT 2**
Number of Apartments and Nursing Beds in Sample

| | Principally Retirement Center | Oriented Toward Nursing Care |
|---|---|---|
| **Number in Sample of:** | | |
| Apartments | 15,714 | 3,805 |
| Nursing Beds | 3,707 | 4,789 |
| **Average Number of Apartments for Each Nursing Bed** | 4.24 | .79 |



## Acreage

Exhibit 3 presents acreage information by type of facility and location. The acreage of the site depends somewhat on proximity to urban centers, with the trend toward increasing acreage as properties are located further from an urban center. The number of apartment residents per acre also declined in rural and suburban areas, although not all categories followed this pattern.

## Square footage statistics

Principally retirement center apartment complexes that were built in 1977 and later are substantially larger than those built before 1977. However, the number of square feet in *each* apartment did not vary significantly either because of age or because the facility was oriented toward nursing care. As expected, personal care units were smaller than regular apartment quarters. Exhibit 4 provides further details, including the differences between lower and upper quartile figures.

## Nursing center beds

Ideally, communities with nursing centers on premises should have enough nursing beds to supply the eventual need of a mature retirement center. Most states have regulations that state a nursing station can have no more than 60 beds, and Exhibit 5 indicates that the median number of beds for newer communities is 60. The median number of apartments for each nursing bed is four for all the facilities, but the newer complexes have 5.4 apartments for each bed. Personal care units may act as a substitute for nursing beds for some residents, and this may account for the trend.

## Marketing results

This year marks the first time we are reporting the marketing costs per unit for communities built after 1977, as shown in Exhibit 6. The median response of the communities that reported this information was $2,763 per unit sold. This year's responses indicated a median of 13 months of preconstruction sales to reach 50 percent of units sold compared with 12 months in last year's study. Our 1984 study showed 66 percent of the units were filled during the first six months compared with 60 percent this year. However, the median response this year showed that 15 months of operation were needed to achieve 95 percent occupancy, whereas last year's figure was 18 months.

**EXHIBIT 3**
Acreage

| | Principally Retirement Center | | | Oriented Toward Nursing Care | | |
|---|---|---|---|---|---|---|
| | Lower Quartile | Median | Upper Quartile | Lower Quartile | Median | Upper Quartile |
| **Acreage** | | | | | | |
| All Facilities | 6.3 | 18.0 | 40.8 | 10.0 | 22.0 | 45.0 |
| **Location:** | | | | | | |
| Urban | 4.0 | 8.0 | 19.0 | 8.0 | 22.0 | 26.0 |
| Suburban | 14.0 | 36.5 | 55.8 | 10.0 | 26.0 | 50.0 |
| Rural | 12.0 | 43.0 | 96.0 | 5.3 | 45.0 | 58.0 |
| **Number of Apartment Residents Per Acre** | | | | | | |
| Total | 8.5 | 18.9 | 35.5 | 1.8 | 5.2 | 10.6 |
| **Location:** | | | | | | |
| Urban | 15.1 | 24.9 | 44.6 | 3.9 | 5.8 | 19.5 |
| Suburban | 3.5 | 8.0 | 17.0 | 2.1 | 6.0 | 8.7 |
| Rural | 1.3 | 10.2 | 19.0 | 0.7 | 1.8 | 9.7 |

**EXHIBIT 4**
Square footage statistics

| | Total | | | |
|---|---|---|---|---|
| | Lower Quartile | Median | Upper Quartile | Under 200 Apartments |
| **Total Area of:** | | | | |
| Apartment Complex | 82,925 | 141,372 | 236,902 | 86,947 |
| Nursing Center | 9,600 | 18,360 | 24,000 | 14,293 |
| Activities Center | 12,000 | 29,125 | 49,850 | 25,000 |
| Personal Care/ Assisted Living Center | 7,150 | 11,720 | 21,500 | 10,720 |
| **Apartment Size:** | | | | |
| Studio/Room | 300 | 375 | 423 | 303 |
| One-Bedroom Apartment | 541 | 615 | 705 | 595 |
| Two-Bedroom Apartment | 810 | 940 | 1,119 | 900 |
| **Personal Care/Assisted Living Size:** | | | | |
| Two Beds Per Room | 137 | 306 | 481 | 300 |
| Private Room | 232 | 300 | 422 | 235 |
| One Bedroom Unit | 295 | 590 | 629 | ** |

*All amounts are medians. **Insufficient data.

**EXHIBIT 5**
Nursing Center Bed Analysis

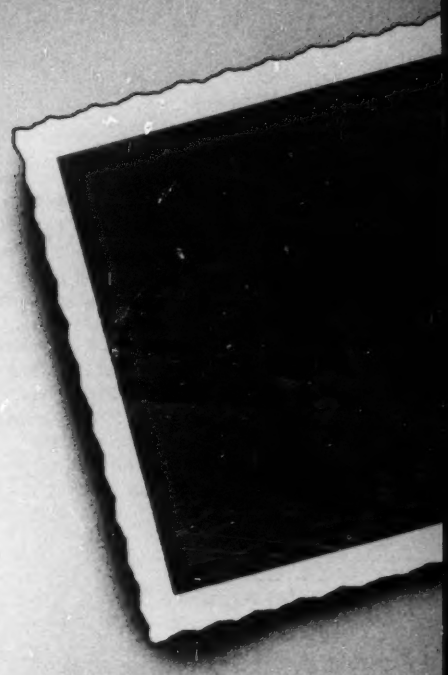
| | Total | | | |
|---|---|---|---|---|
| | Lower Quartile | Median | Upper Quartile | Under 200 Apartments |
| Number of Beds Per Community | 38.1 | 55.2 | 61.2 | 40.0 |
| Number of Apartments Per Bed | 2.7 | 4.0 | 5.5 | 3.2 |

*All amounts are medians.

## EXHIBIT 6
Marketing Costs, Pre-Construction Sales Results and Fill-up Time For Communities Built 1977 and Later*

| | |
|---|---|
| Marketing Cost Per Unit | $2,763 |
| Number of Months of Pre-Construction Sales to Reach 50% | 13 |
| **Percentage of Apartment Units Filled During:** | |
| 1st Six Months | 60% |
| 2nd Six Months | 16% |
| 3rd Six Months | 20% |
| **Number of Months to Achieve 95% Occupancy** | 15 |

*All amounts are medians.



Principally Retirement Center — Oriented Toward Nursing Care

| Size* | Age* | | Total | | |
|---|---|---|---|---|---|
| 200 Apartments or More | Built Pre-1977 | Built 1977 and Later | Lower Quartile | Median | Upper Quartile |
| | | | | | |
| 236,805 | 131,635 | 221,874 | 29,881 | 56,555 | 120,773 |
| 21,100 | 17,886 | 21,170 | 24,540 | 35,800 | 47,159 |
| 30,600 | 26,180 | 41,702 | 11,400 | 24,716 | 36,377 |
| 13,100 | 12,000 | 11,439 | 19,219 | 33,685 | 66,532 |
| | | | | | |
| 382 | 350 | 400 | 265 | 360 | 425 |
| 660 | 640 | 600 | 557 | 600 | 683 |
| 953 | 952 | 900 | 900 | 975 | 1,008 |
| | | | | | |
| 365 | 313 | 130 | 257 | 293 | 338 |
| 320 | 300 | ** | 218 | 270 | 298 |
| 595 | 564 | ** | 242 | 511 | 615 |

Principally Retirement Center — Oriented Toward Nursing Care

| Size* | Age* | | Total | | |
|---|---|---|---|---|---|
| 200 Apartments or More | Built Pre-1977 | Built 1977 and Later | Lower Quartile | Median | Upper Quartile |
| 60.0 | 53.8 | 60.0 | 60.2 | 98.3 | 144.0 |
| 5.2 | 3.6 | 5.4 | 0.5 | 0.8 | 1.4 |

## Market area

Exhibit 7 contains information, presented for the first time this year, about the size of the primary market area as estimated by the respondents. For principally retirement center facilities, 80 percent indicated their primary market area as being within a 25-mile radius or less, with 45 percent selecting a 15-mile or less radius. The median response was that 80 percent of the residents come from within their primary market area. Interestingly, about 50 percent of the residents were estimated to have children living within 30 minutes driving time. Presumably this would mean half had children living in the primary market area.

## Apartment entrance fees

Exhibit 8 illustrates the wide range of entrance fees between the lower and upper quartiles in practically every category. In almost all cases, those facilities whose nursing care coverage is insured and provided without any substantial extra charges, "insured," were substantially higher than facilities "not insured." Presumably the difference is similar to a single premium insurance payment.

**EXHIBIT 7**
Primary Market Area and Proximity to Children:

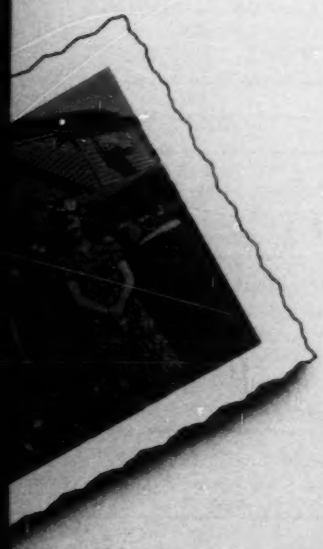
| | Principally Retirement Center | Oriented Toward Nursing Care |
|---|---|---|
| **Percentage of Communities Which Estimate Their Primary Market Area to be:** | | |
| 5 to 10 Mile Radius | 24% | 24% |
| 11 to 15 Mile Radius | 21 | 6 |
| 16 to 20 Mile Radius | 13 | 6 |
| 21 to 25 Mile Radius | 22 | 37 |
| Over 25 Mile Radius | 20 | 27 |
| **Percentage of Residents Estimated to Come From Within Their Primary Market Area:** | | |
| Lower Quartile | 60% | 75% |
| Median | 80 | 80 |
| Upper Quartile | 90 | 90 |
| **Percentage of Residents Who Have Children Estimated to Live Within 30 Minutes Driving Time*:** | | |
| Urban Communities | 45% | 50% |
| Surburban or Rural Communities | 55 | 62 |

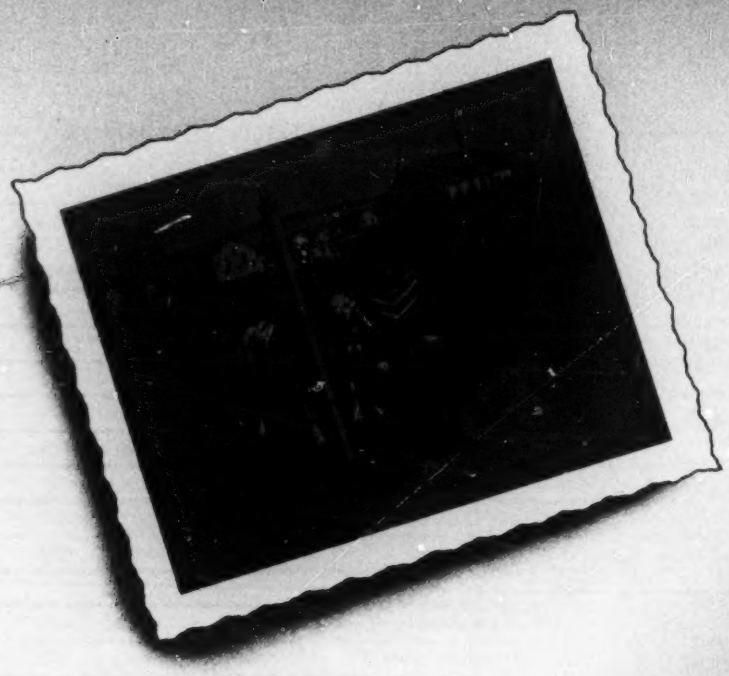
*Amounts are medians

**EXHIBIT 8**
Apartment Entrance Fees—By Age and Whether Nursing Care Coverage is Insured and Provided Without Extra Charge or Not Insured.

| | Studio/Room Fee | | | |
|---|---|---|---|---|
| | Lower Quartile | Median | Upper Quartile | Lower Quartile |
| **Principally Retirement Center** | | | | |
| All Facilities | $18,500 | $24,500 | $35,000 | $33,365 |
| **Built Pre-1977:** | | | | |
| Insured | 21,746 | 27,000 | 38,200 | 34,596 |
| Not Insured | 17,000 | 20,000 | 23,500 | 26,750 |
| **Built 1977 and Later:** | | | | |
| Insured | 35,000 | 38,000 | 48,000 | 57,000 |
| Not Insured | 17,675 | 24,316 | 28,875 | 29,900 |
| **Oriented Toward Nursing Care** | | | | |
| All Facilities | 11,769 | 19,500 | 30,375 | 21,000 |
| **Built Pre-1977:** | | | | |
| Insured | 15,000 | 29,250 | 38,625 | 16,750 |
| Not Insured | 11,192 | 18,000 | 20,000 | ** |

**Insufficient Data





| One-Bedroom Fee | | Two-Bedroom Fee | | | Three-Bedroom Fee | | |
|---|---|---|---|---|---|---|---|
| Median | Upper Quartile | Lower Quartile | Median | Upper Quartile | Lower Quartile | Median | Upper Quartile |
| $45,000 | $56,750 | $55,175 | $71,108 | $78,800 | $55,229 | $75,581 | $96,000 |
| 47,700 | 57,875 | 54,500 | 71,715 | 76,375 | 55,913 | 65,000 | 80,000 |
| 37,500 | 45,500 | 45,125 | 57,500 | 69,629 | ** | ** | ** |
| 60,500 | 67,000 | 75,000 | 78,000 | 88,000 | 93,750 | 96,000 | 105,250 |
| 47,335 | 57,522 | 46,625 | 71,933 | 78,800 | ** | ** | ** |
| 32,430 | 42,700 | 31,625 | 41,771 | 61,875 | 12,875 | 55,443 | 93,775 |
| 44,900 | 60,250 | 41,750 | 60,750 | 81,250 | ** | ** | ** |
| 26,000 | ** | ** | ** | ** | ** | ** | ** |

## Monthly apartment fees

Exhibit 9 shows monthly apartment fees for various size units by location, age of facility and larger versus smaller complexes. Generally, the upper quartile figures are at least 50 percent greater than the lower quartile ones, indicating the wide variation in types of facilities responding to the study questionnaire. We also attempted to analyze the difference between "insured" and "not insured" projects as was done in Exhibit 8 with entrance fees, but found no pattern between the two types of projects. Consequently we have not included such information in the study.

## Nursing center daily rates

Exhibit 10 displays the range of rates between the lower and upper quartile. Particularly with regard to private room rates the range is a broad one indicating the varying types of facilities responding to the study.

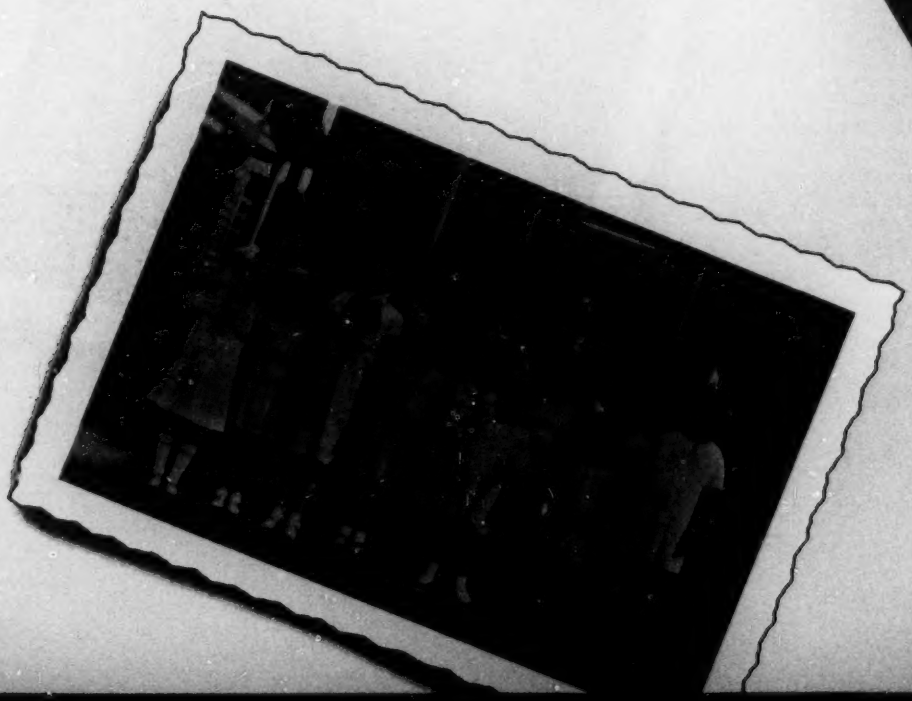
**EXHIBIT 9**
Monthly Apartment Fees By Selected Criteria

| | Studio/Room | | | |
|---|---|---|---|---|
| | Lower Quartile | Median | Upper Quartile | Lower Quartile |
| **Principally Retirement Center** | | | | |
| All Facilities | $530 | $599 | $700 | $602 |
| **Location:** | | | | |
| Urban | 530 | 625 | 700 | 605 |
| Suburban | 558 | 588 | 734 | 602 |
| **Age:** | | | | |
| Built Pre-1977 | 530 | 637 | 717 | 642 |
| Built 1977 and Later | 480 | 560 | 572 | 585 |
| **Size:** | | | | |
| Under 200 Apartments | 515 | 639 | 713 | 645 |
| 200 Apartments or More | 530 | 560 | 700 | 587 |
| **Oriented Toward Nursing Care** | | | | |
| All Facilities | 485 | 625 | 815 | 579 |
| **Location:** | | | | |
| Urban | 465 | 624 | 780 | 609 |
| Suburban | 485 | 625 | 980 | 338 |

**EXHIBIT 10**
Nursing Center Daily Rates

| | Private Room | | | Semiprivate Room | | |
|---|---|---|---|---|---|---|
| | Lower Quartile | Median | Upper Quartile | Lower Quartile | Median | Upper Quartile |
| **Principally Retirement Center** | | | | | | |
| Skilled | $65.75 | $83.00 | $106.00 | $52.75 | $63.50 | $73.75 |
| Intermediate | 53.75 | 83.00 | 102.75 | 50.00 | 64.00 | 67.00 |
| **Oriented Toward Nursing Care** | | | | | | |
| Skilled | 61.25 | 81.00 | 98.75 | 56.00 | 65.50 | $73.50 |
| Intermediate | 53.25 | 59.00 | 73.00 | 44.00 | 53.00 | 60.00 |

| One Person | | | | | Second Person Additional | |
|---|---|---|---|---|---|---|
| One-Bedroom | | Two-Bedroom Fee | | | One Bedroom | Two Bedrooms |
| Median | Upper Quartile | Lower Quartile | Median | Upper Quartile | Median | Median |
| $700 | $ 905 | $682 | $829 | $1,093 | $318 | $338 |
| 736 | 923 | 709 | 823 | 1,195 | 279 | 295 |
| 683 | 901 | 682 | 826 | 959 | 421 | 487 |
| 782 | 952 | 736 | 857 | 1,143 | 305 | 305 |
| 602 | 647 | 682 | 682 | 1,038 | 392 | 446 |
| 842 | 929 | 756 | 940 | 1,100 | 305 | 307 |
| 652 | 849 | 682 | 780 | 1,069 | 359 | 384 |
| 670 | 1,009 | 300 | 700 | 795 | 250 | 233 |
| 752 | 870 | 695 | 726 | 795 | 240 | 233 |
| 795 | 1,291 | 184 | 682 | 1,524 | 421 | 477 |



## Rate increases

It's interesting to note in Exhibit 11 that the median percentage increase in apartment rates is slightly lower for 1984 than it was for 1983 and is closely following the Consumer Price Index trend. Nursing center percentage rate increases have been somewhat greater for both 1983 and 1984 than apartment rate increases.

## Patient days in the nursing center

Exhibit 12 shows the number of patient days the principally lifecare apartment residents or former apartment residents spent in the community nursing center. The usage by temporary patients staying in the nursing facility is approximately the same number of days per apartment resident per year in both the older and newer facilities. However, as expected, the older facilities had a substantially higher ratio of permanent transfer patients.

The number of nursing beds in use in a theoretical facility with 300 residents is determined by multiplying the patient days per resident per year by the number of residents, then dividing the results by 365. In Exhibit 12, a 300-resident principally retirement center facility built before 1977 had a median of 6.7 filled beds on a temporary basis and 39.6 beds for permanent transfers.

## Loss of nursing facility revenue

Exhibit 13 displays data concerning the loss of revenue per apartment unit in principally retirement center facilities as a result of residents who pay only apartment rate charges while occupying a higher priced nursing bed on a permanent basis. Additionally, temporary stay patients generally pay nothing toward the nursing bed because they are paying only for the apartment unit they occupy. As the figures indicate, permanent transfers are a substantial expense, especially for the older communities built before 1977.

**EXHIBIT 11**
Apartment and Nursing Center Percentage Rate Increases*

| | Percentage Increase in Apartment Rates | Percentage Increase in Nursing Care Rates |
|---|---|---|
| **Principally Retirement Center** | | |
| 1984 | 5.0 | 6.0 |
| 1983 | 5.5 | 7.5 |
| 1982 | 9.0 | 9.0 |
| **Oriented Toward Nursing Care** | | |
| 1984 | 5.0 | 5.0 |
| 1983 | 5.0 | 7.0 |
| 1982 | 8.0 | 10.0 |

*All amounts are medians.

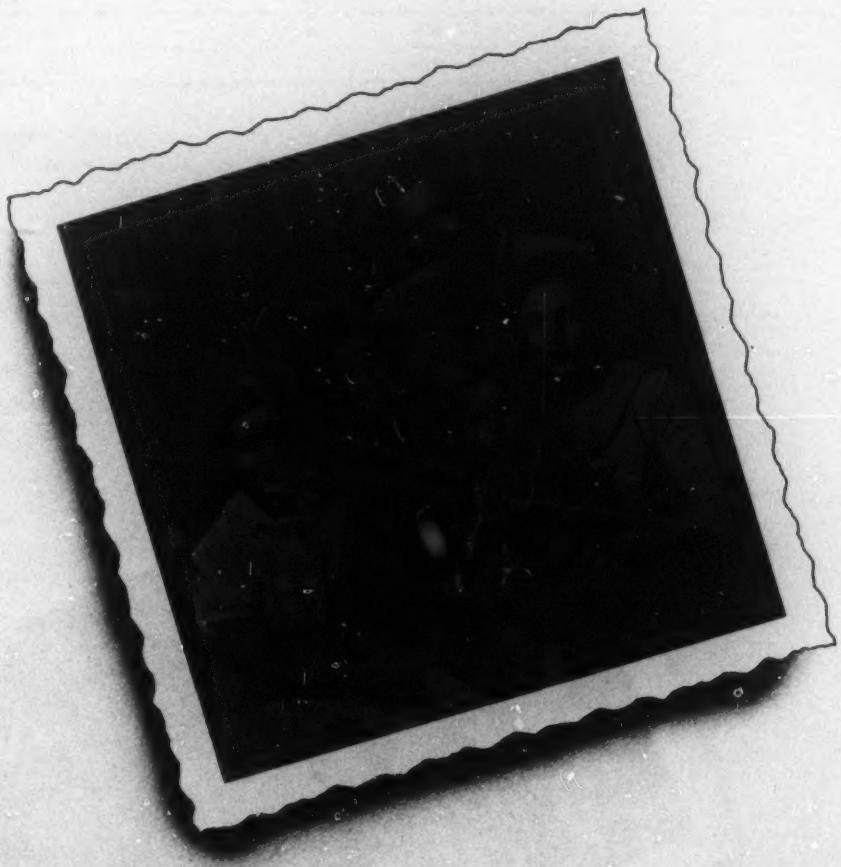


**EXHIBIT 12**
Patient Days in Nursing Center by Principally Retirement Center Residents or Former Residents

| | Lower Quartile | Median | Upper Quartile |
|---|---|---|---|
| **Patient Days Per Apartment Resident Per Year:** | | | |
| **Temporary:** | | | |
| Built Pre-1977 | 3.5 | 8.1 | 15.2 |
| Built 1977 and Later | 3.5 | 8.3 | 18.3 |
| **Permanent:** | | | |
| Built Pre-1977 | 29.1 | 48.1 | 65.1 |
| Built 1977 and Later | 8.8 | 24.9 | 54.1 |
| **Number of Beds Occupied Per Day in Nursing Care Center for a Facility with 300 Apartment Residents:** | | | |
| **Temporary:** | | | |
| Built Pre-1977 | 2.9 | 6.7 | 12.5 |
| Built 1977 and Later | 2.9 | 6.9 | 15.1 |
| **Permanent:** | | | |
| Built Pre-1977 | 23.9 | 39.6 | 53.5 |
| Built 1977 and Later | 7.3 | 20.5 | 44.5 |

**EXHIBIT 13**
Loss of Nursing Facility Revenue in Principally Retirement Center*

| | 1984 Loss of Revenue Per Apartment | |
|---|---|---|
| | Permanent Transfers | Temporary Transfers |
| **All Facilities:** | $2,209 | $473 |
| **Location:** | | |
| Urban | 2,312 | 454 |
| Suburban/Rural | 2,123 | 475 |
| **Age of Apartments:** | | |
| Built Pre-1977 | 2,304 | 473 |
| Built 1977 or Later | 706 | 454 |

*All amounts are medians.

## Average age of residents

Exhibit 14 presents the average age of residents upon entrance to apartments during the last three years and the average age of all residents during 1984. A close comparison of the ages for 1984 and the 1983 ones given in last year's study indicates a creep upward in the mean age. For example, the entry age for females in principally retirement centers was 77 last year and is 78 for 1984. The mean age in 1984 of both males and females rose one and a half years for males and two years for females. This is not totally accounted for by the aging of residents in the same facilities that contributed to last year's study since, in many cases, the 1985 study contains responses from different communities than the 1984 study. As expected, the communities built before 1977 had a mean age population two to four years older than the more recently built communities.

## Financial assistance

All but four of the communities included in the study are nonprofit entities and agree to provide services to their residents even if they are unable to pay. Some communities build up special funds contributed by residents to cover such contingencies, and others use current operating funds. Exhibit 15 shows that a median of 3 percent of residents currently require financial assistance. This compares with last year's median of 4.2 percent. Also, the estimated percentage of people who may eventually require assistance rose to 8 percent this year from 5 percent in the 1984 study. The questionnaire did not attempt to identify the amount of assistance provided.

## Months on facility waiting list

Exhibit 16 provides the medians for duration of time on the waiting list to enter a principally retirement center. The older facilities have waiting periods twice as long as facilities built in 1977 and later. It's also interesting to note that older facilities have the longest wait for two-bedroom units, but the newer facilities have apparently anticipated the market demand more accurately and the one-bedroom unit, usually the most popular, has the longest wait.

### EXHIBIT 14
Average Age of Residents*

| | Residents' Average Age at Entry to Apartments During the Last Three Years | | Average Age of All Residents 1984 | |
|---|---|---|---|---|
| | Male | Female | Male | Female |
| **Principally Retirement Center** | | | | |
| All Facilities | 78.0 | 78.0 | 82.0 | 82.0 |
| **Age of Apartments:** | | | | |
| Built Pre-1977 | 78.0 | 78.0 | 82.0 | 83.0 |
| Built 1977 or Later | 79.0 | 77.0 | 80.0 | 79.0 |
| **Oriented Toward Nursing Care** | | | | |
| All Facilities | 79.0 | 80.0 | 81.5 | 81.5 |
| **Age of Apartments:** | | | | |
| Built Pre-1977 | 78.0 | 80.0 | 82.0 | 82.0 |
| Built 1977 or Later | ** | ** | 81.0 | 80.0 |

*All amounts are medians.
**insufficient data

### EXHIBIT 15
Financial Assistance for Principally Retirement Center

| | |
|---|---|
| **Percentage of Residents Who Currently Require Financial Assistance —All Facilities:** | |
| Lower Quartile | 1.9% |
| Median | 3.0 |
| Upper Quartile | 6.8 |
| **Percentage of Residents Who May Eventually Require Assistance:** | |
| Median | 8.0% |

### EXHIBIT 16
Waiting List for Principally Retirement Center*

| | Built Pre-1977 | Built 1977 and Later |
|---|---|---|
| **Number of Months on Facility Waiting List:** | | |
| Studio/Room | 12 | 6 |
| One-Bedroom | 24 | 14 |
| Two-Bedroom | 25 | 6 |

*All amounts are medians.

## Percentage of males and females

Each year since this study's inception, there has been a ratio of approximately four women for each man in the average retirement community. The 1985 study follows the same trend. Also, as in the past year, communities oriented toward nursing care have a higher percentage of male residents, but the margin is very small this year. Exhibit 17 includes the range reported by all respondents to reflect the wide differences between the numbers of males and females in various types of communities.

## Annual apartment turnover

Exhibit 18 shows the wide differences in annual apartment turnover between the older and newer principally retirement centers. It is especially striking in the 1977 and later facilities to note that male turnover is so much greater than female turnover. The 11.5 median rate for apartment turnover for 1984 translates into 30 or more apartments becoming vacant each year for a facility having 300 residents.

**EXHIBIT 17**
Percentage of Males and Females

| | Principally Retirement Center | | | | Oriented Toward Nursing Care | | | |
|---|---|---|---|---|---|---|---|---|
| | Mean | | Range | | Mean | | Range | |
| | Male | Female | Male | Female | Male | Female | Male | Female |
| 1984 | 21.1 | 78.9 | 2.3-39 9 | 60.1-97.7 | 22.4 | 77.6 | 10.0-46.4 | 53.6-90.0 |
| 1983 | 21.1 | 78.9 | 11.2-46.9 | 53.1-88.8 | 22.2 | 77.8 | 11.1-47.2 | 52.8-88.9 |
| 1982 | 21.4 | 78.6 | 11.8-45.5 | 54.5-88.2 | 22.7 | 77.3 | 8.3-45.9 | 54.1-91.7 |

**EXHIBIT 18**
Annual Apartment Turnover per 100 Residents*

| | Deaths | | Permanent Transfers To Nursing Center | | Total Turnover | | | |
|---|---|---|---|---|---|---|---|---|
| | Males | Females | Males | Females | Males | Females | Combined** | Comparison With 1984 Study |
| **Principally Retirement Center** | | | | | | | | |
| **Pre-1977 Facilities:** | | | | | | | | |
| 1984 | 9.1 | 5.7 | 5.6 | 5.3 | 14.7 | 10.7 | 11.5 | 9.3 |
| 1983 | 7.2 | 5.4 | 4.3 | 4.6 | 11.5 | 10.0 | 10.3 | 8.9 |
| 1982 | 6.6 | 4.3 | 4.5 | 4.1 | 11.1 | 8.4 | 9.0 | 10.6 |
| **1977 and Later Facilities:** | | | | | | | | |
| 1984 | 5.4 | 3.5 | 4.3 | 2.9 | 9.7 | 6.4 | 7.1 | 6.3 |
| 1983 | 8.1 | 3.1 | 2.5 | 2.4 | 10.6 | 5.5 | 6.6 | 7.3 |
| 1982 | 7.7 | 3.0 | 4.8 | 1.5 | 12.5 | 4.5 | 6.2 | 6.9 |
| **Oriented toward Nursing Care** | | | | | | | | |
| **Pre-1977 Facilities:** | | | | | | | | |
| 1984 | 7.0 | 2.8 | 9.1 | 12.5 | 16.1 | 15.3 | 15.6 | *** |
| 1983 | 10.7 | 4.1 | 12.1 | 12.1 | 22.8 | 16.2 | 18.8 | *** |
| 1982 | 9.4 | 3.3 | 14.3 | 10.3 | 23.7 | 13.6 | 16.4 | *** |

*All amounts are medians.
**Taking into consideration previously stated proportion of females and males for each year.
***Data not available.

## Salaries and number of employees

In addition to breaking down the data by quartiles, Exhibit 19 includes the 10 and 90 percentiles to provide the reader with a broader range of the salary data reported. The additional breakdowns of personal care staff, vehicle drivers and social activities staff have been added to last year's classifications.

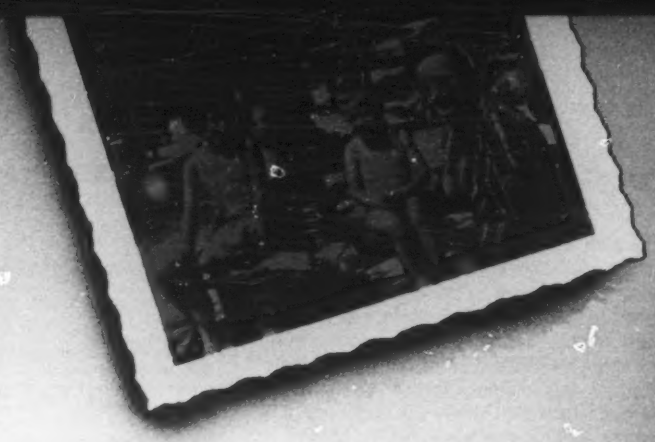
The annual payroll of a theoretical (median) principally retirement center is calculated below by using the median number of employees and multiplying it by the median salary for those positions. Such a community would contain about 200 apartments, a 60-bed nursing center and a 25-bed personal care unit.

| | Number of full-time equivalent employees | Gross annual salary ($000 omitted) |
|---|---|---|
| Nursing center, including administrative | 33.0 | $ 391 |
| Personal care | 6.0 | 68 |
| Dietary | 23.0 | 211 |
| All other employees | 35.8 | 454 |
| TOTAL | 97.8 | $1,124 |

**EXHIBIT 19**
Payroll Information—Salaries and Number of Employees

| | All Facilities—By Percentiles | | | | |
|---|---|---|---|---|---|
| | 10% | 25% | 50% | 75% | 90% |
| **Principally Retirement Center** | | | | | |
| **Salary per Person for:** | | | | | |
| Executive Director or Administrator | $30,000 | $35,773 | $40,000 | $45,000 | $56,500 |
| Assistant Executive Director | 21,079 | 22,400 | 28,000 | 35,813 | 38,899 |
| Social Activities Staff | 8,422 | 10,011 | 13,367 | 15,432 | 16,667 |
| Administrative (Excluding Nursing) | 9,167 | 11,350 | 13,590 | 16,164 | 18,243 |
| Vehicle Drivers | 6,000 | 7,606 | 8,708 | 11,685 | 13,957 |
| Nursing Center Administrator | 18,000 | 22,000 | 24,665 | 28,160 | 32,296 |
| Adminstrative (Nursing) | 10,000 | 12,480 | 14,487 | 18,609 | 25,333 |
| Nursing Staff | 8,840 | 10,054 | 11,242 | 12,886 | 15,916 |
| Personal Care Staff | 6,072 | 9,715 | 11,371 | 13,025 | 17,143 |
| Dietary | 7,076 | 8,267 | 9,156 | 10,744 | 13,508 |
| Housekeeping/Laundry | 7,500 | 8,102 | 9,511 | 11,181 | 13,432 |
| Maintenance | 9,194 | 11,775 | 13,851 | 16,098 | 19,841 |
| Security | 6,000 | 7,810 | 10,524 | 11,496 | 14,258 |
| All Other | 6,333 | 9,438 | 11,723 | 16,107 | 20,000 |
| **Oriented Toward Nursing Care** | | | | | |
| **Salary per Person for:** | | | | | |
| Executive Director or Administrator | 18,307 | 32,200 | 35,000 | 41,842 | 51,286 |
| Assistant Executive Director | 22,360 | 22,500 | 28,476 | 34,000 | 35,164 |
| Social Activities Staff | 8,469 | 9,907 | 12,707 | 15,068 | 16,718 |
| Administrative (Excluding Nursing) | 9,103 | 10,569 | 13,835 | 18,278 | 25,948 |
| Vehicle Drivers | 6,000 | 6,741 | 9,508 | 11,922 | 12,433 |
| Nursing Center Administrator | 20,000 | 22,464 | 24,025 | 28,000 | 40,000 |
| Administrative (Nursing) | 9,942 | 13,633 | 17,350 | 21,161 | 24,343 |
| Nursing Staff | 7,786 | 9,843 | 11,784 | 13,222 | 14,527 |
| Personal Care Staff | 6,000 | 9,497 | 10,861 | 14,301 | 16,110 |
| Dietary | 7,375 | 8,197 | 9,999 | 11,742 | 14,047 |
| Housekeeping/Laundry | 6,764 | 7,941 | 9,791 | 11,154 | 11,579 |
| Maintenance | 9,818 | 10,998 | 12,417 | 14,570 | 17,984 |
| Security | 8,317 | 10,000 | 10,950 | 13,738 | 15,098 |
| All Other | 8,480 | 9,393 | 11,156 | 15,094 | 17,782 |

*All amounts are medians. **Insufficient data



| Size* | | Location* | | Number of Employees All Facilities—by Percentiles | | | | |
|---|---|---|---|---|---|---|---|---|
| Under 200 Apartments | 200 Apartments or More | Urban | Surburban/ Rural | 10% | 25% | 50% | 75% | 90% |
| | | | | | | | | |
| $37,270 | $43,000 | $39,200 | $40,000 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| 24,500 | 35,250 | 28,103 | 28,000 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| 11,637 | 14,500 | 12,788 | 13,909 | 1.0 | 1.0 | 2.0 | 3.0 | 4.0 |
| 12,517 | 15,578 | 13,329 | 14,194 | 2.0 | 3.0 | 5.5 | 8.5 | 17.0 |
| 11,670 | 8,543 | 8,708 | 9,604 | ** | 1.0 | 1.0 | 1.9 | ** |
| 22,500 | 27,000 | 24,500 | 25,000 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| 14,487 | 14,239 | 14,062 | 16,190 | 1.0 | 1.0 | 2.0 | 4.7 | 10.0 |
| 10,452 | 12,238 | 12,078 | 11,014 | 13.5 | 21.5 | 30.0 | 41.0 | 57.0 |
| 12,438 | 10,519 | 12,164 | 10,798 | 2.0 | 4.0 | 6.0 | 7.0 | 26.0 |
| 9,103 | 9,901 | 8,827 | 10,141 | 12.0 | 17.6 | 23.0 | 35.4 | 52.5 |
| 9,370 | 9,510 | 10,153 | 9,125 | 4.0 | 8.0 | 11.5 | 18.0 | 28.0 |
| 13,214 | 14,939 | 14,108 | 13,562 | 2.0 | 3.0 | 5.0 | 9.5 | 15.5 |
| 7,962 | 11,350 | 10,077 | 11,226 | 1.0 | 1.5 | 2.5 | 5.0 | 14.0 |
| 10,029 | 12,946 | 11,271 | 14,019 | 1.5 | 3.0 | 6.3 | 11.6 | 30.0 |
| | | | | | | | | |
| | | | | | | | | |
| ** | ** | 39,000 | 33,529 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| ** | ** | 31,616 | 26,500 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| ** | ** | 13,017 | 11,590 | 1.0 | 1.0 | 2.0 | 3.0 | 4.0 |
| ** | ** | 15,791 | 12,498 | 2.0 | 3.0 | 5.5 | 8.5 | 12.5 |
| ** | ** | 9,508 | 9,676 | .5 | 1.0 | 1.0 | 1.9 | 10.5 |
| ** | ** | 23,742 | 24,652 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| ** | ** | 18,820 | 17,350 | 1.0 | 1.0 | 2.0 | 5.0 | 15.5 |
| ** | ** | 11,920 | 11,946 | 25.0 | 29.5 | 49.5 | 71.4 | 145.5 |
| ** | ** | 12,650 | 9,915 | 2.0 | 4.0 | 6.0 | 7.0 | 26.0 |
| ** | ** | 9,499 | 10,229 | 12.5 | 15.5 | 22.5 | 36.1 | 44.5 |
| ** | ** | 9,816 | 10,059 | 8.0 | 10.0 | 13.5 | 21.0 | 32.0 |
| ** | ** | 13,489 | 11,388 | 2.0 | 3.5 | 5.0 | 7.0 | 13.0 |
| ** | ** | 11,087 | ** | 1.0 | 1.5 | 3.0 | 5.3 | 7.0 |
| ** | ** | 10,528 | 11,511 | 1.5 | 2.8 | 6.5 | 30.0 | 79.0 |

## Payroll and employee statistics

The wide range of operating statistics for various facilities is illustrated by the wide variance between the lower and upper quartile in Exhibit 20. Surprisingly, the median cost statistics between the communities with less than 200 apartments and the larger ones does not consistently demonstrate the benefits of economy of scale. Likewise, the comparisons of the median statistics between the newer and older facilities does not show consistently lower costs for the newer facilities.

## Various expense statistics

Exhibit 21 shows the effect of inflation on the raw food cost and utilities expense during the past three years. Exhibit 22 shows the wide variation during 1984 of operating costs among the respondents to the study.

## Reserve funds

The questionnaire asked the communities the amount of funds they were holding in reserves for purposes other than debt service or mortgage repayment. By dividing the amounts by the number of apartment residents of each community we calculated the reserves per resident. Exhibit 23 provides this information.

**EXHIBIT 20**
Payroll and Employee Statistics

| | Principally Retirement Center | | | | |
|---|---|---|---|---|---|
| | Total | | | Size* | |
| | Lower Quartile | Median | Upper Quartile | Under 200 Apartments | 200 Apartments or More |
| **Dietary Department** | | | | | |
| Dietary Payroll Per Meal | $1.14 | $1.52 | $1.86 | $1.45 | $1.60 |
| **Housekeeping and Maintenance Department** | | | | | |
| Housekeeping Payroll Per Square Foot of Entire Facility | .48 | .66 | .90 | .68 | .63 |
| Maintenance Payroll Per Square Foot of Entire Facility | .35 | .45 | .65 | .43 | .48 |
| Square Feet Per Housekeeper | 10,870 | 15,731 | 20,654 | 14,069 | 17,337 |
| Square Feet Per Maintenance Employee | 21,078 | 31,650 | 42,830 | 30,389 | 32,572 |
| **All Departments** | | | | | |
| Total Number of Residents and Patients Per Employee | 1.9 | 2.6 | 3.3 | 2.6 | 2.7 |
| Cost of Employee Medical Benefits Per Employee | 362 | 582 | 700 | 525 | 647 |

*All amounts are medians.

**EXHIBIT 21**
Various Expense Statistics—Three-Year Comparison

| | Principally Retirement Center | | | Oriented Toward Nursing Care | | |
|---|---|---|---|---|---|---|
| | Total | | | Total | | |
| | Lower Quartile | Median | Upper Quartile | Lower Quartile | Median | Upper Quartile |
| **Raw Food Cost Per Meal** | | | | | | |
| 1984 | $1.14 | $1.38 | $1.71 | $ .91 | $1.11 | $1.32 |
| 1983 | 1.03 | 1.38 | 1.59 | .90 | 1.03 | 1.23 |
| 1982 | 1.00 | 1.29 | 1.48 | .75 | .90 | 1.24 |
| **Utilities Expense Per Square Foot** | | | | | | |
| 1984 | $1.04 | $1.23 | $1.48 | $ .97 | $1.16 | $1.49 |
| 1983 | .90 | 1.10 | 1.26 | 1.00 | 1.18 | 1.40 |
| 1982 | .87 | 1.04 | 1.30 | .80 | 1.09 | 1.36 |

| Oriented Toward Nursing Care | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Age of Apartments* | | Location* | | Total | | | Location* | |
| Built Pre-1977 | Built 1977 and Later | Urban | Surburban/ Rural | Lower Quartile | Median | Upper Quartile | Urban | Suburban/ Rural |
| $1.56 | $1.40 | $1.53 | $1.47 | $1.04 | $1.20 | $1.55 | $1.34 | $1.09 |
| .74 | .44 | .65 | .66 | .72 | 1.05 | 1.24 | 1.11 | 1.05 |
| .46 | .44 | .43 | .50 | .35 | .41 | .55 | .46 | .40 |
| 14,621 | 21,689 | 15,870 | 15,125 | 7,583 | 10,375 | 13,745 | 9,323 | 10,573 |
| 31,650 | 31,856 | 32,048 | 31,105 | 21,886 | 31,619 | 40,792 | 33,290 | 28,618 |
| 2.6 | 2.6 | 2.7 | 2.3 | 1.5 | 1.8 | 2.1 | 1.8 | 1.8 |
| 588 | 571 | 582 | 570 | 349 | 449 | 652 | 639 | 433 |

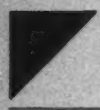
**EXHIBIT 22**
Various Expense Statistics—1984

| | Principally Retirement Center | | | | | Oriented Toward Nursing Care | | |
|---|---|---|---|---|---|---|---|---|
| | Total | | | Size* | | Total | | |
| | Lower Quartile | Median | Upper Quartile | Under 200 Apartments | 200 Apartments or More | Lower Quartile | Median | Upper Quartile |
| Raw Food Cost Per Meal | $1.14 | $1.38 | $1.71 | $1.24 | $1.00 | $.91 | $1.11 | $1.32 |
| Utilities Expense Per Square Foot | 1.04 | 1.23 | 1.48 | 1.21 | 1.26 | .97 | 1.16 | 1.49 |
| Cost of Food Management Service Per Meal | .11 | .18 | .30 | .15 | .20 | .05 | .09 | .17 |
| Annual Medical Cost Per Apartment Resident | $98 | $319 | $534 | $290 | $319 | $287 | $889 | ** |

*All amounts are medians.
**Insufficient response.

**EXHIBIT 23**
Reserve Funds Other Than Debt Service or Mortgage Payment Reserves.

| | Principally Retirement Center | | | Oriented Toward Nursing Care | | |
|---|---|---|---|---|---|---|
| | Lower Quartile | Median | Upper Quartile | Lowe Quartile | Median | Upper Quartile |
| Total Amount of All Reserves | $284,608 | $1,059,018 | $3,516,694 | $229,223 | $669,000 | $1,793,668 |
| Total Reserves Per Resident | 1,447 | 7,194 | 13,765 | 1,671 | 6,609 | 23,286 |



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